IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TENNESSEE
WESTERN DIVISION

MILTON SCOTT,	)	
	)	
Plaintiff,	)	
	)	
v.	)	No. 04-2714 M1/V
	)	
ASSURANT EMPLOYEE BENEFITS, f/k/a FORTIS BENEFITS INSURANCE COMPANY,	)	
	)	
Defendant.	)	

ORDER DENYING PLAINTIFF'S MOTION FOR PARTIAL SUMMARY JUDGMENT AND DENYING IN PART AND GRANTING IN PART DEFENDANT'S MOTION FOR PARTIAL SUMMARY JUDGMENT

Before the Court is Plaintiff's Motion for Partial Summary Judgment, filed November 3, 2004, and Defendant's Motion for Partial Summary Judgment, filed January 13, 2005. Defendant responded to Plaintiff's Motion for Partial Summary Judgment on December 27, 2004. Plaintiff responded to Defendant's Motion for Partial Summary Judgment on February 17, 2005,[1] and Defendant filed a Reply on May 16, 2005. For the following reasons, Plaintiff's motion for partial summary judgment is DENIED and Defendant's motion for partial summary judgment is DENIED in part and GRANTED in part.

[1] Plaintiff's Motion to Enlarge Time to respond to Defendant's Motion for Partial Summary Judgment, filed February 14, 2005, is hereby GRANTED.

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I. Background and Relevant Facts

The issue before the Court arises in the context of Plaintiff's suit to recover benefits under a Group Long-term Disability Insurance Policy (the "Policy") issued by Defendant to Plaintiff's employer, Logistical Systems, Inc. ("LSI"), on December 15, 2001. Plaintiff alleges that on May 7, 2002, he underwent a kidney transplant, and, as a result of his "renal problems coupled with long standing cardiac conditions," he is fully disabled within the meaning of the Policy and is physically incapable of work. (Compl. ¶ 7.) From May 7, 2002, until April 4, 2003, Defendant paid Plaintiff long-term disability benefits pursuant to the LSI's group insurance policy. (Id. ¶ 8.) On April 9, 2003, Defendant informed Plaintiff by letter that no further benefits would be paid. (Id.)

On August 3, 2004, Plaintiff filed a complaint against Defendant in the Circuit Court of Shelby County, Tennessee, for the Thirtieth Judicial District at Memphis.[2] Plaintiff alleges that (1) Defendant materially breached its contract with Plaintiff to provide long-term disability benefits in violation of Defendant's duty of good faith and fair dealing; (2) Defendant's "representation of services was unfair, deceptive

[2] Plaintiff filed his complaint against "Assurant Employee Benefits, f/k/a Fortis Benefits Insurance Company." Defendant identifies itself as "Fortis Benefits Insurance Company ('Fortis'), incorrectly sued as Assurant Employee Benefits, f/k/a Fortis Benefits Insurance Company."

and/or unconscionable" in violation of the Tennessee Consumer Protection Act, T.C.A. § 47-18-109(a)(3) and (c)(4); and (3) Defendant refused in bad faith to pay Plaintiff within sixty days of "Plaintiff's legitimate request for payment of benefits" thereby rendering it liable for a twenty-five percent penalty, in addition to Plaintiff's loss and interest pursuant to T.C.A. § 56-7-105. Plaintiff requests various forms of relief. (Compl. ¶¶ 13,14,18,24.)

On September 10, 2004, Defendant removed the action to the District Court of the Western District of Tennessee,[3] alleging the existence of (1) diversity jurisdiction; and (2) federal question jurisdiction on the basis that Plaintiff's state-law claims are preempted by the Employment Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001, et seq. Plaintiff filed an Amended Complaint on October 7, 2004, to allege a cause of action for improper denial of disability benefits under ERISA. On October 20, 2004, Defendant filed an Answer to the Amended Complaint and asserted several affirmative defenses, including that the Policy is an "employee welfare benefit plan" governed by ERISA. On November 3, 2004, Plaintiff moved for partial summary judgment on Defendant's affirmative defense that Plaintiff's claim is governed by ERISA. Plaintiff asserts that the Policy

[3] This case was originally assigned to Judge Bernice B. Donald. It was transferred to Judge McCalla on March 2, 2005.

falls within the Department of Labor's "safe harbor" regulations and thus is not governed by ERISA. Defendant responded on December 27, 2004, moving for partial summary judgment on the basis of ERISA preemption.[4]

II. Standard of Review

Under Federal Rule of Civil Procedure 56(c), summary judgment is proper "if the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to judgment as a matter of law." Fed. R. Civ. P. 56(c); see also Celotex Corp. v. Catrett, 477 U.S. 317, 322 (1986). So long as the movant has met its initial burden of "demonstrat[ing] the absence of a genuine issue of material fact," Celotex, 477 U.S. at 323, and the nonmoving party is unable to make such a showing, summary judgment is appropriate. Emmons v. McLaughlin, 874 F.2d 351, 353 (6th Cir. 1989). In considering a motion for summary judgment, "the evidence as well as all inferences drawn therefrom must be read in a light most favorable to the party opposing the motion." Kochins v. Linden-Alimak, Inc., 799 F.2d 1128, 1133 (6th Cir.

[4] On January 13, 2005, Defendant filed an Errata to correct the title of its December 27, 2004, brief. It also filed a motion that should have been submitted contemporaneously with the brief. As corrected, Defendant's submission is titled Opposition to Plaintiff's Motion for Partial Summary Judgment and Memorandum Brief in Support of Fortis's Motion for Partial Summary Judgment.

1986); see also Matsushita Elec. Indus. Co. v. Zenith Radio Corp., 475 U.S. 574, 587 (1986).

When confronted with a properly-supported motion for summary judgment, the nonmoving party "must set forth specific facts showing that there is a genuine issue for trial." Fed. R. Civ. P. 56(e); see also Abeita v. TransAmerica Mailings, Inc., 159 F.3d 246, 250 (6th Cir. 1998). A genuine issue of material fact exists for trial "if the evidence [presented by the nonmoving party] is such that a reasonable jury could return a verdict for the nonmoving party." Anderson v. Liberty Lobby, Inc., 477 U.S. 242, 248 (1986). In essence, the inquiry is "whether the evidence presents a sufficient disagreement to require submission to a jury or whether it is so one-sided that one party must prevail as a matter of law." Id. at 251-52.

The standard of review for cross-motions of summary judgment does not differ from the standard applied when only one party files a motion. Taft Broad. Co. v. U.S., 929 F.2d 240, 248 (6th Cir. 1991). "The fact that both parties have moved for summary judgment does not mean that the court must grant judgment as a matter of law for one side or the other; summary judgment in favor of either party is not proper if disputes remain as to material facts. Rather, the court must evaluate each party's motion on its own merits." Id. (citations omitted). Thus, when the court reviews cross-motions for summary judgment, it "must

evaluate each motion on its own merits and view all facts and inferences in the light most favorable to the nonmoving party." Westfield Ins. Co. v. Tech Dry, Inc., 336 F.3d 503, 506-07 (6th Cir. 2003).

III. Analysis

The issue before the Court is whether Plaintiff's long-term disability insurance policy ("the Policy") is part of an "employee welfare benefit plan" governed by ERISA. If the Policy is an ERISA plan, Plaintiff's claims under Tennessee state law are preempted and federal common law will apply. Thompson v. American Home Assurance Co., 95 F.3d 429, 434 (6th Cir. 1996)(citing Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 56-57 (1987)). Title I of ERISA defines an "employee welfare benefit plan" as:

> any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization . . . for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) . . . benefits in the event of sickness, accident, disability, death or unemployment . . . .

29 U.S.C. § 1002(1) (1997).

The Sixth Circuit has developed a three-step factual inquiry to determine whether a benefit plan satisfies the statutory definition set out in § 1002(1). Thompson, 95 F.3d at 434; see also Wausau Benefits v. Progressive Ins. Co., 270 F.Supp.2d 980, 986 (S.D. Ohio 2003). First, a court must apply the Department

of Labor's "safe harbor" regulations to determine if the plan is exempt from ERISA governance. Thompson, 95 F.3d at 434. A benefit plan is exempt if it satisfies all four requirements of the "safe harbor" regulations, which provide:

> [T]he terms "employee welfare benefit plan" and "welfare plan" shall not include a group or group-type insurance program offered by an insurer to employees or members of an employee organization, under which
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> (1) No contributions are made by an employer or employee organization;
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> (2) Participation in the program is completely voluntary for employees or members;
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> (3) The sole functions of the employer or employee organization with respect to the program are, without endorsing the program, to permit the insurer to publicize the program to employees and members, to collect premiums through payroll deductions or dues checkoffs and to remit them to the insurer; and
>
> (4) The employer or employee organization receives no consideration in the form of cash or otherwise in connection with the program, other than reasonable compensation, excluding any profit, for administrative services actually rendered in connection with payroll deductions or dues checkoffs.

29 C.F.R. § 2510.3-1(j). "A policy will be exempted under ERISA only if all four of the 'safe harbor' criteria are satisfied." Thompson, 95 F.3d at 435 (emphasis added). The second step in a court's factual inquiry is to determine if a "plan" exists by examining "whether 'from the surrounding circumstances a reasonable person [could] ascertain the intended benefits, the class of beneficiaries, the source of financing, and procedures for receiving benefits.'" Id. (quoting Int'l Resources, Inc. v.

New York Life Ins. Co., 950 F.2d 294, 297 (6th Cir. 1991)). Finally, a court must determine whether the employer "established or maintained" the plan "with the intent of providing benefits to its employees." Thompson, 95 F.3d at 435.

Before the Court are the parties' cross-motions for partial summary judgment. Plaintiff argues for partial summary judgment on Defendant's affirmative defense that Plaintiff's state law claims are preempted by ERISA. Plaintiff asserts that the Policy is not governed by ERISA because it falls within the Department of Labor's "safe harbor" regulations, and, as such, his state law claims are not preempted. Defendant denies that the safe harbor provisions apply and moves this Court to enter partial summary judgment in its favor as to Plaintiff's state law claims, arguing that they are preempted by ERISA.

A. Safe Harbor Regulations

1. Employer Contribution

The first criterion to examine under the safe harbor regulation is whether LSI—the employer—contributed to the cost of the Policy. 29 C.F.R. § 2510.3-1(j)(1). The parties agree that LSI paid its employees' insurance premiums under the Policy from December 15, 2001, the date the coverage went into effect,

through sometime in April 2002.[5] They also agree that Plaintiff paid the premiums starting in either April or May 2002.[6] According to Lentz Gatlin, LSI's Chief Financial Officer, LSI converted the plan from "100% employer paid" to "100% employee paid" in April of 2002. (Letter from Lentz Gatlin to Craig Wright, Fortis Group Benefits, of 4/24/02, Mem. Supp. Pl.'s Resp. Def.'s Mot. Partial Summ. J., Ex B ("4/24/02 Gatlin Letter").)[7]

Plaintiff argues, however, that as construed under ERISA, he and the other LSI employees "constructively paid" the premiums throughout the entire period. Defendant argues that, under the meaning of ERISA, LSI paid the premiums throughout the entire period. Alternatively, Defendant claims, since LSI paid the

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[5] In his Complaint, Plaintiff asserted that "[i]rrespective of the group nature of the disability policy, [he] was covered outside the group and paid his own premiums." (Compl. ¶ 6.) Later, however, Plaintiff stated that "[b]etween the period of December 15, 2001 and April 2002, LSI directly paid the insurance premiums for its salaried employees" and that he does not dispute the fact that LSI "initially paid the premiums for the Policy. (Mem. Support Pl. Response Def.'s Mot. Partial Summ. J. at 3, 6.)

[6] In its Response to Plaintiff's Statement of Material Facts, Defendant states that it "admits that Scott paid the premiums required under the Policy after May 2, 2002."

[7] There is some evidence, however, that this change was never effected. Defendant submitted an affidavit from Cheryl Wood, its Managing Team Risk Leader and an underwriter for the company, who states that LSI requested that Defendant amend the Policy to provide for employer payment of the premiums, but that Fortis never completed the amendment. (Wood Aff. ¶ 2.) She goes on to note that the Policy "remains non-contributory, [however,] Fortis recently learned that LSI started deducting the required premiums from employees' pay in May 2002." (Id.)

insurance premiums during the first several months, it "established" the Policy as an ERISA plan, and the fact that it may not have been "maintained" as an ERISA plan does not preclude a finding that LSI's insurance policy is an ERISA plan for the purposes of this litigation. The Court will address the parties' contentions in turn.

Plaintiff argues that although LSI technically paid the cost of the premiums from December 15, 2001, through sometime in April 2002, these payments "may be seen as constructively paid by the employees themselves." (Mem. Support Pl.'s Response Def.'s Mot. Partial Summ. J. at 6.) He claims that the only reason LSI did not deduct the cost of the premiums from its employees' gross income prior to April 2002 was because the company considered the payments to be "fringe benefits" that were not includable in its employees' salary. Once LSI "realized" it could deduct the cost of the premiums if they were considered wages as opposed to fringe benefits, LSI "quickly recharacterized the premiums as salary (and therefore gross income to their employees)." (Id. at 8.) Plaintiff claims that "LSI would have reported the premiums as gross income to their employees from December to April if they could have, or if they would have had the right tax advice at the time." (Id. at 9.) Thus, Plaintiff concludes, LSI "never really wished to actively contribute to their employees' welfare, [and] their role must be seen as a neutral one." (Id.)

While employer neutrality is a critical component of plans exempt from ERISA under the safe harbor regulations, see Thompson, 95 F.3d at 436, the Court finds Plaintiff's argument on this point unavailing. Plaintiff puts forward no evidence to support his claim that LSI's "recharacterization" of the premium payments from fringe benefits to salary makes it "apparent that LSI never really wished to actively contribute to their employees' welfare" (Mem. Support Pl.'s Response Def.'s Mot. Partial Summ. J. at 9.) Nor does Plaintiff cite any authority for the proposition that as a result of this intent, LSI's payments prior to April 2002 should be viewed as constructive payments by the employees. The Court thus finds Plaintiff's argument without merit.

Defendant's argument on the issue of employer contribution is the converse of Plaintiff's. Defendant concedes that Plaintiff paid the Policy premiums after May 2, 2002, but contends that LSI still "contributed to" the Policy—under the meaning of ERISA—by giving its employees a raise "for the express purpose of covering the premium deductions." (Opp. Pl.'s Mot. Partial Summ. J. and Mem. Support Def.'s Mot. Partial Summ. J. ¶ 2; Reply Brief Support Def.'s Mot. Partial Summ. J. at 3.)

In support of its contribution-via-reimbursement argument, Defendant relies on Grimo v. Blue Cross & Blue Shield of Vt., 899 F. Supp. 196 (D. Vt. 1995). The Grimo court held that the safe

harbor provision did not apply where the employer corporation deducted the cost of the insurance premiums from the corporation's earnings—money that otherwise would have gone to the employee shareholders—and then gave its employees "a bonus equal to the amount of premiums that had been paid plus any taxes and costs that had been incurred in the process."[8] 899 F.Supp. at 199 (emphasis added). The court concluded that in this manner, the corporation "fully absorbed the health insurance costs of its shareholders . . . ." Id.

In the instant action, LSI gave its salaried employees an "increase in wages" starting in May 2002. By including this "increase" in the employees' gross income (and listing it on their W-2s), however, the employees had to pay taxes on the extra amount. There is nothing in the record that shows LSI reimbursed its employees for the additional taxes they incurred as a result of the increase in gross income. Unlike in Grimo, then, LSI did not "fully absorb" all of the costs of the premium payments. Rather, because LSI included the cost of the premiums on its employees' W-2 forms as gross income, the employees "contributed to" the cost of their long-term disability insurance, not LSI. See B-T Dissolution, Inc. v. Provident Life and Accident Ins. Co., 175 F. Supp. 2d 978, 983 (S.D. Ohio 2001) (holding that the

[8] The opinion does not specify whether the bonus was taxable or listed as gross income on the shareholders' W-2 forms.

employer did not "contribute" to its employees' disability insurance policies under 29 C.F.R. § 2510.3-1(j)(1) because "the full amount of the premiums . . . was included on [the employees'] W-2 forms as gross income"). As in B-T Dissolution, LSI wrote the premium checks directly to Defendant, but those funds "necessarily first 'passed through'" its employees, who were required to report this amount as gross income and pay taxes on it. Id. Accordingly, the Court finds that the LSI employees, not LSI, contributed to the plan after April 2002.

Defendant argues, however, that because LSI paid the insurance premiums for the first several months, it "established" an ERISA plan under the plain language of the statute. That the plan was not "maintained" as an ERISA plan does not mean that ERISA no longer governs. As a general proposition, Defendant's argument is valid. See Nix v. United Health Care of Ala., Inc., 179 F.Supp.2d 1363, 1369 (M.D. Ala. 2001)(finding ERISA plan where employer set up insurance plan for both owners and employees, but later all employees ceased to work for employer, leaving only owners covered, because statute's plain meaning does not require that "plan must be established and continuously maintained as an ERISA plan"); Nat'l Bus. Ass'n Trust v. Morgan, 770 F.Supp. 1169, 1174-75 (W.D. Ky. 1991) (holding ERISA governed trust fund established by group of employers even though fund not maintained by employers under plain language of statute).

The Court notes that it is not entirely clear that LSI's past premium payments take it out of the safe harbor regulations. The Second Circuit has held that the use of the present tense in the plain language of 29 C.F.R. § 2510.3(j)(1)—"No contributions are made"—"strongly suggests that past payments do not forever preclude the application of the safe harbor provision." Grimo v. Blue Cross/Blue Shield of Vt., 34 F.3d 148, 153 (2d Cir. 1994). The court concluded that "any employer contribution made in the past, no matter how long ago or under what circumstances, does not preclude application of 29 C.F.R. § 2510.3(j)(1) or demonstrate that an employer has 'established or maintained' the plan under 29 U.S.C. § 1002(1)." Id.

The evidence in this case is that employer contributions were made to the cost of the plan during the period generally contemporaneous with the relevant coverage in this case. Therefore, summary judgment must be granted on the first safe harbor criterion. The Court GRANTS Defendant's motion for summary judgment on the employer contribution criterion. Because a policy will be exempted under ERISA only if all of the safe harbor criteria are met, and because the first criterion is not met, the policy in this case is not excluded from ERISA coverage under the safe harbor regulations.

2. Voluntary Participation[9]

In order to qualify for safe harbor exemption, a plan must also be "completely voluntary." 29 C.F.R. § 2510.3-1(j)(2). Plaintiff submits that participation in the group long-term disability insurance coverage plan was "arguably voluntary" from December 2001 through April 2002 and that it is "unclear" whether participation became mandatory after April 2002. Defendant contends, however, that participation was mandatory at all times.

Participation in a plan is not completely voluntary when an employer guarantees a minimum participation rate at the time the policy contract is created and the rate of participation is subsequently met. Chamblin v. Reliance Standard Life Ins. Co., 168 F. Supp. 2d 1168, 1171 (N.D. Cal. 2001). The purpose of the "voluntariness" prong "is to identify programs sponsored by the employer and meant to be a benefit of employment." The Meadows v. Employers Health Ins., 826 F. Supp. 1225, 1229 (D. Ariz. 1993) (finding plan failed to satisfy "voluntariness" prong of safe harbor provision where employer agreed to 100% participation of all eligible employees for insurance coverage and 75% participation for medical coverage on group insurance application). By requiring 100% participation, an employer has "demonstrated its intent to establish an insurance plan for its

[9] The Court examines the second safe harbor criterion because it constitutes an additional ground for granting summary judgment on the issue for Defendant.

employees." Id. ("If the benefit was meant to be an option for employees there would be no participation requirement of 75% or 100%.")

Here, the evidence in the record plainly supports a finding that participation in LSI's long-term disability insurance plan was not completely voluntary. LSI's Group Insurance Preliminary Application, dated December 4, 2001, states that the total number of full-time employees was 51 and the total number of participating employees was also 51. (Opp. Pl.'s Mot. Partial Summ. J. and Mem. Support Def.'s Mot. Partial Summ. J., Ex. D ("Application") ¶ 10.) The Policy also notes that there are "Minimum Participation Requirements"[10] (Opp. Pl.'s Mot. Partial Summ. J. and Mem. Support Def.'s Mot. Partial Summ. J., Ex. C ("Group Long-Term Disability Insurance Policy"), at 10) and explains that the Policy will "end if the number or percentage of persons covered under the policy does not meet the Minimum Participation Requirements show in the Schedule" (id. at 28). Defendant's internal records show LSI requested that the long-term disability plan "be changed from non-contributory to 100% employee paid," effective May 1, 2002, and that LSI specified that "this will be a mandatory benefit, therefore [LSI] will

[10] Specifically, the Policy states "Minimum Participant Requirements: Number: 10; Percentage: 100%." (Group Long-Term Disability Insurance Policy, at 10.)

maintain 100% participation in the plan."[11] (Opp. Pl. Mot. Partial Summ. J. and Mem. Support Def.'s Mot. Partial Summ. J., Ex. B at 5.) Finally, LSI's Chief Financial Officer, Lentz Gatlin, wrote a letter to Defendant on April 24, 2002, in which he stated that the long-term disability insurance plan had 100% participation from all LSI employees and that the amended plan would be "a mandatory benefit; therefore [LSI] will still have 100% participation in this program." (2/24/02 Gatlin Letter.)

To support his contention that the plan was completely voluntary, Plaintiff refers the Court to a question left unanswered in the Policy Application which asks "[i]s participation in the Fortis coverage(s) mandatory?" (Application ¶ 10.) He also points to the affidavit of Cheryl Wood, Defendant's Managing Team Risk Leader. Wood states that "in April 2002, LSI requested that Fortis amend the Policy to require mandatory participation in coverage by its employees . . . ." (Wood Aff. ¶ 4) (emphasis added). Plaintiff argues that this language demonstrates that participation was not voluntary until April 2002, and furthermore, that participation never became mandatory because Defendant never completed the requested amendment. See supra n.7. Plaintiff also submitted to the Court

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[11] As noted earlier, there is some evidence in record that this amendment was never fully effected by Defendant. See supra n.7. Nevertheless, it is clear that participation in the plan was mandatory prior to the amendment request and that it was LSI's intent to maintain mandatory participation.

an affidavit in which he states that it was his understanding that participation in the plan voluntary. (Pl. Aff. ¶ 3.) The Court finds this evidence too speculative and inconclusive to create a genuine issue of material fact on the voluntariness requirement.

The Sixth Circuit "has long held that '[m]ere conclusory and unsupported allegations, rooted in speculation, do not meet [the] burden'" of demonstrating the existence of a genuine issue for trial. Bell v. Ohio State U., 351 F.3d 240, 253 (6th Cir. 2003) (quoting Bryant v. Commw. of Ky., 490 F.2d 1273, 1275 (6th Cir. 1974)). The conclusory allegations in Plaintiff's affidavit add nothing to the allegations in his complaint and therefore fail to create a triable issue of fact on the voluntariness prong of the safe harbor regulations. See Davidson v. United States, 6 Fed. Appx. 317, 319 (6th Cir. Mar. 12, 2001). Upon review of the record, the Court concludes that participation in the long-term disability insurance plan was not completely voluntary. As with the first safe harbor criterion, because a plan must satisfy every requirement of the safe harbor provision to be exempt from ERISA regulation, the Court GRANTS summary judgment in favor of Defendant on the safe harbor exemption issue and DENIES summary judgment to the Plaintiff.[12]

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[12] Based on the Court's ruling as to the first two safe harbor criteria, it is unnecessary to examine the parties' arguments under (continued ...)

B. Existence of a Plan

Even if a court determines that a plan is not exempt from ERISA coverage under the safe harbor regulations, it must still complete the second and third steps in the Sixth Circuit's three-part test set forth in Thompson. 95 F.3d at 437. Under the second Thompson factor, an ERISA plan exists if "a reasonable person can ascertain (1) the intended benefits, (2) the class of beneficiaries, (3) the source of financing, and (4) the procedures for receiving benefits." Williams v. WCI Steel Co., Inc., 170 F.3d 598, 602 (6th Cir. 1999) (noting that the Sixth Circuit and every other Circuit has adopted this test for determination of whether plan exists under ERISA). Defendant argues that any reasonable person looking at the Policy could "easily ascertain" that it "provides long-term disability coverage for full-time LSI employees, that the premiums required by the Policy were paid by LSI, and the procedures for submitting claims under the Policy." (Opp. Pl.'s Mot. Partial Summ. J. and Mem. Support Def.'s Mot. Partial Summ. J at 6.)

The record before the Court supports a finding that a plan exists under ERISA in this case. The Policy explicitly states that it pays benefits "designed to partly replace income lost

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(continued ...)
the third safe harbor requirement. As to the fourth requirement—that the employer does not receive consideration for its role in the program—there is no dispute that the safe harbor criterion is met.

during periods of disability that result from injury, sickness, or pregnancy." (Group Long-Term Disability Insurance Policy at 9.) It further specifies that employees will receive "60% of monthly pay subject to a maximum Schedule Amount of $6,000 per month . . . ." and explains other aspects of the benefits, including the qualifying period and monthly payment limit." (Id. at 10.) The "Eligible Class" is defined as each "full-time[13] employee of the policy holder . . . who is at active work . . . in the United States . . . ." (Id.) The Policy explains that the policyholder—specified as LSI on the cover page—must pay all premiums (id. at 29) and that Fortis is the source of the benefit payments (id. at 10). The procedure for receiving benefits is summarized in a section of the Policy titled "Filing a Claim" and "Proof of Loss." (Id. at 24.)

Plainly, a reasonable person could ascertain the particulars of LSI's group insurance policy. The benefits are not "amorphous" or "too ephemeral and contingent for [the court] to ascertain, what, if anything [LSI] intends an employee to receive." Williams, 170 F.3d at 603 (quoting Siemon v. AT&T Corp., 117 F.3d 1173, 1179 (10th Cir. 1997)). Nor are they "ad hoc . . . arrangements" such that a court could not determine whether an LSI employee was covered under the plan, what benefits

[13] Full-time employees are defined as those working at least thirty hours per week. (Id. at 3.)

might be due, or otherwise fashion appropriate relief. See Diak v. Dwyer, Costello & Knox, P.C., 33 F.3d 809, 813 (7th Cir. 1994).

Plaintiff has not put forward any evidence to suggest that a reasonable person would not be able to ascertain the pertinent features of LSI's long-term disability insurance policy. In fact, Plaintiff did not address the second step in the Court's inquiry at all. Accordingly, Court concludes that there is no genuine issue of material fact as to the existence of a "plan" under ERISA and GRANTS summary judgment to Defendant on this factor.

C. Established or Maintained

The final step in the Court's inquiry is to determine whether LSI "established or maintained" the plan with an intent to provide benefits to its employees. An employer has established or maintained an employment welfare benefit plan where it "consulted an insurance agent, selected the terms of the group policy it wished to purchase for its employees, completed an application form for the policy, solicited enrollments from its employees, collected money through payroll deductions, and remitted premium checks to [the insurance company.]" Anderson v. UNUM Provident Corp., 369 F.3d 1257, 1267-68 (11th Cir. 2004) (quoting Butero v. Royal Maccabees Life Ins. Co., 174 F.3d 1207, 1214 (11th Cir. 1999)); see also McDonald v. Provident Indem.

Life Ins. Co., 60 F.3d 234, 236 (5th Cir. 1995) (finding employer "established or maintained" the plan by purchasing insurance, selecting benefits, identifying employee-participants, and distributing enrollment and claim forms).

Defendant claims that LSI "established or maintained" the long-term disability insurance plan through various means. According to Defendant, LSI procured the insurance coverage for its employees by submitting an application, paying $853.05 to be applied toward the first premium due, and selecting the extent and scope of coverage, e.g., deciding that its current employees would be immediately eligible for coverage but that new employees must wait one month. (See Application ¶¶ 8,9,10)

Plaintiff argues, however, that LSI did nothing to establish or maintain the Policy. In support, Plaintiff relies primarily on the affidavit of Lentz Gatlin, LSI's CFO. According to Gatlin, the Policy was a "standard long-term disability policy" and neither LSI nor its employees determined the scope of coverage. LSI did not negotiate the terms of the Policy, and the book that LSI employees received on the Policy was prepared by Defendant, not LSI. (Gatlin Aff. ¶¶ 9,10.)

Having reviewed the record and the parties' contentions, the Court concludes that a genuine issue of material fact exists as to whether LSI "endorsed or maintained" the Policy under the meaning of ERISA. The Court notes, in particular, that LSI is

not the designated plan administrator, and the record reveals no evidence that LSI took part in the plan's day-to-day administration. In addition, the parties have put forward conflicting accounts of LSI's role in negotiating the terms and benefits of the policy. Gatlin states that "[n]either LSI nor its employees determined the scope of coverage under the policy [and] LSI did not negotiate the terms of the policy." (Gatlin Aff. ¶ 9.) Fortis's Managing Team Risk Leader, on the other hand, states that LSI selected the scope of the plan's coverage and its eligibility requirements. (Wood Aff. ¶ 3.)

Other courts that have found that an employer "established or maintained" a plan within the scope of ERISA have based this conclusion on a much stronger factual record than the evidence before this Court. See, e.g., Grimo v. Blue Cross and Blue Shield of Vt., 899 F. Supp. 196, 205 (D. Vt. 1995) (finding employer "established or maintained" an ERISA plan in part on evidence of employer's extensive administrative responsibilities, including distributing claim forms, submitting employee insurance cards, selecting deductible amounts, and engaging in "substantial bookkeeping and records management to maintain the operation of the payment system"). Here, the evidence in the record appears to be in material dispute as to whether LSI "established or maintained" the Policy with an intent to provide benefits to its employees as construed under ERISA. The Court concludes that

Plaintiff has set forth sufficient evidence to create a genuine issue of material fact on this question. Accordingly, the Court DENIES Defendant's motion for summary judgment as to whether the plan is governed by ERISA and accordingly, on Defendant's ERISA preemption claim.

IV. Conclusion

For the reasons set forth above, the Court DENIES summary judgment on Plaintiff's claim that the safe harbor regulations exempt the plan from ERISA and GRANTS summary judgment on this issue in Defendant's favor. The Court also GRANTS Defendant's motion for summary judgment as to whether a "plan" exists under the meaning of ERISA. Finally, the Court DENIES Defendant's motion for summary judgment as to whether LSI "established or maintained" the plan with an intent to provide benefits to its employees. Accordingly, the Court DENIES Defendant's motion for summary judgment as to whether Plaintiff's state law claims are preemted by ERISA.[14]

So ORDERED this 30 day of September, 2005.

JON P. McCALLA
UNITED STATES DISTRICT JUDGE

[14] Because the Court denies summary judgment on the issues of ERISA governance and state law claim preemption, it declines to address Plaintiff's savings clause argument at this time.

UNITED STATES DISTRICT COURT - WESTERN DISTRICT OF TENNESSEE

Notice of Distribution

This notice confirms a copy of the document docketed as number 46 in case 2:04-CV-02714 was distributed by fax, mail, or direct printing on October 3, 2005 to the parties listed.

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